COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2382-03
Bill No.: Perfected HS for HCS for HB 3
Subject: Social Services Department; Pharmacy; Public Assistance
Type: Original
Date: September 10, 2001

FISCAL SUMMARY

ESTIMATED NET EFFECT ON STATE FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
General Revenue	($575,124)	($30,920,160)	($24,905,658)
Pharmaceutical Investment Program for Seniors#	$3,335,430	$0	$0
Total Estimated Net Effect on All State Funds	**$2,760,306**	**($30,920,160)**	**($24,905,658)**

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Federal	$0	$0	$0
Total Estimated Net Effect on All Federal Funds*	**$0**	**$0**	**$0**

***Revenues and expenditures of approximately $28 million annually would net to $0.**

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Local Government	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.

This fiscal note contains 24 pages.

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Office of State Treasurer**, the **Office of State Courts Administrator**, and the **Department of Revenue** assume this proposal would not fiscally impact their agencies.

Department of Social Services (**DOS**) officials assume the following:

Officials from the **Division of Family Services** (**DFS**) state the following:

Income/Resources Expansion

The DFS would need to hire additional staff and develop policy to accommodate the necessary changes for the expansion of income and resources to the adult Medicaid populations. Implementation of this portion of the proposal would begin January 1, 2002.

The proposal provides that the income eligibility limit be expanded to 100% of the Federal Poverty Level (FPL) for those individuals receiving old age assistance benefits or permanent and total disability benefits. Currently 100% of the FPL is $716 for a single individual and $968 for a couple.

Based on data from the FY 2000 DOS Annual Data Report published by Research and Evaluation there are 11,882 QMB cases, and 6,860 SLMB cases. This data is based on average persons receiving monthly for FY 2000 and should provide a more accurate count of individuals impacted.

This proposal would have a negligible fiscal impact on both the GR and SAB programs. The GR population may have a small percentage of cases that have income in the month of application greater than $181 (Need standard for a 1 person household) but less than or equal to the SSI maximum of $530. This is typically a result of terminated income from employment. Affect on eligibility would be limited to the month of application. SAB individuals rejected in the past on excessive resources usually qualify for the Blind Pension program since it has a $20,000 resource maximum.

65% of the total population would qualify for the single resource maximum and 35% of the total population would qualify for the couple resource maximum, as reported by the Health Care Finance Administration (Medicare Current Beneficiary Survey Data Tables, 1997, Table 1.2)

65% of the current Qualified Medicare Beneficiary (QMB) and Specified Low-income Medicare

Beneficiary (SLMB) program participants are living alone. 37.5% of this population would be eligible for Medicaid based on the increased resource limits (1,500/4000 - Single QMB/SLMB ASSUMPTION (continued)

resource limit = 37.5%). For the SLMB population, the income limits is greater than 100% of the FPL therefore, this population would be spenddown.

35% of the current Qualified Medicare Beneficiary (QMB) and Specified Low-income Medicare Beneficiary (SLMB) program participants are living with a spouse. 41.66% (2,500/6,000 Couple QMB/SLMB resource limit= 41.66%) of this population would be eligible for Medicaid based on the increased resource limits. For the SLMB population, the income limits is greater than the 100% of the FPL therefore, this population would be spenddown.

The global Medicare population in Missouri is 800,000. Assume this group to be the new population from outside of the current welfare rolls to seek Medicaid benefits.

800,000	Medicare Population
520,000	Living Alone (65%)
280,000	Living with a Spouse (35%)

According to a study completed by the Public Policy Institute of AARP #9914 dated September 1999 entitled: "How Much Are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?", 10% of Medicare beneficiaries have income less than or equal to 100% of the FPL and resources at or below the QMB/SLMB resource maximums. Based on this information, DFS anticipates that one out of 10 or 10% of the Medicare population would be eligible to apply for Medicaid under the new expanded income limits.

280,000	Medicare Population Living with a Spouse
x 10%	Income below 100% of the FPL
28,000	

Fiscal Impact - Expanded Resource and Income Limits

Total populations included

7,301	- Active QMB/SLMB only cases with resources at $1,500/$2,500
10,908	- New full Medicaid eligibles (previously Spenddown)
975	- New cases (single Medicare)
+ 583	- New cases (couple Medicare)
19,767	- Total Eligibles

MW:LR:OD (12/00)

The Active QMB/SLMB only cases and additional spenddown cases that are currently being maintained in a caseload will not require additional staff for DFS.

ASSUMPTION (continued)

975 - New single Medicare cases
+ 583 - New couple Medicare cases
1,558 - New Eligibles

An average adult Medicaid caseload is 480 cases.

1,558 / 480 = 3.24 or 3 new Caseworker FTEs needed to maintain new cases. Caseworker duties and responsibilities include take and process applications for eligibility, respond and answer both written and telephone requests for information or reported changes, and maintain all active cases in caseload.

Annual salary for a Caseworker is $29,040

Pharmaceutical Investment Program for Seniors

The DFS assumes that the Division of Aging within the Department of Health and senior Senior Services would award an RFP to a third-party for the administration of the PIPS therefore its involvement would be negligible. No increases in Medicaid caseloads are anticipated.

The DFS assumes a zero fiscal impact for this portion of the proposal.

Officials from the **Division of Medical Services** (**DMS**) worked with the Division of Family Services to identify the population that is being proposed for full medical assistance. The population includes spenddown, Qualified Medicare Beneficiary (QMB) only, and Blind Pension eligibles. These populations are currently receiving a limited medical services benefit, but this proposal would allow the eligibles to receive the full benefit. Currently, there are 10,908 spenddown eligibles and 37 Blind Pension eligibles affected by increasing income limits. DMS believes there would be individuals that are eligible for the spenddown program, but are not enrolled. DMS assumed that this population might present themselves for medical coverage if this proposal would be adopted, but DMS is unable to estimate this population.

Spenddown - DMS assumed the 10,908 eligibles can be converted from spenddown status to "regular" Medicaid immediately. DMS also assumed a monthly cost of $77.02 (FY 01) which is a weighted average of actual spenddown costs for spenddown eligibles as of August 2000. DMS assumed a 4% increase in medical cost each year and a caseload increase of 3.94% each year.

QMB Only - The estimate for the QMB only population is included in the increase in resource calculation.

Blind Pension - The current caseload for this population is 2,611. DFS assumed that 37 eligibles ASSUMPTION (continued)

of this population would be eligible for the full Medicaid benefits with the proposal. Since the medical payments for this population is currently 100% General Revenue (GR) and since they do not receive the full Medicaid benefits, DMS assumed a reduction in GR and an increase in federal funding for this population.

Claims Processing Cost - DMS estimates the claims processing costs associated with these eligibles at $50,000 per year. These costs are matched at the 50/50 GR/FF rate.

DMS further states a state plan amendment (SPA) would be required to expand the income limit to 100% of the FPL. DMS assumes 6 to 9 months would be required to submit the SPA and obtain approval from the Centers for Medicare and Medicaid Services (CMS). Therefore, the DMS assumes the expanded income limit to 100% of FPL would become effective July 1, 2002.

DMS assumes program (61.06% federal) and claims processing costs of $100,000 (50% GR, 50% Federal) annually.

Officials from the **Department of Health and Senior Services - Division of Aging** (**DA**) state:

Section 208.010 - Would increase resource limits to $2,500 for individual and $4,000 for a couple and Section 208.151. 1. (25) Increases the Income Limit to 100% of Federal Poverty Level.

In determining the fiscal impact of this proposal, DA has made the following assumptions:
- Department of Social Services, Division of Family Services (DFS) would calculate the fiscal impact associated with determining eligibility for under the new requirements;
- Department of Social Services, Division of Medical Services (DMS) would determine the fiscal impact associated with the cost of services for the new group of eligible recipients; and
- Department of Social Services, Division of Legal Services (DLS) would determine the fiscal impact associated with the cost of any administrative hearings.

According to the Department Of Social Services, Research and Evaluation Unit, there were 69,928 Medicaid recipients age 65 and over in FY2000. As of June 30, 2000 the DHSS had authorized in-home services to just over 20,363 Medicaid in-home service recipients age 65 or over. Therefore, the department estimates the participation rate for in-home services is 29.12% (20,363 / 69,928). Additionally, it is projected the client population would grow at a rate of 4%

per year based upon the growth experienced in the Old Age Assistance (OAA) and Permanently and Totally Disabled (PTD) population as provided by the Division of Medical Services. The Department of Health and Senior Services assumes that the spenddown clients and the Blind Pension (PB) clients who become eligible because of the increase in the income requirements who are currently receiving in-home services are already being case managed and, therefore, will ASSUMPTION (continued)

not increase the number of potential eligibles.

Based on information provided by DFS, it is projected that additional Qualified Medicare Beneficiaries (QMB) eligibles and Specified Low-Income Medicare Beneficiaries (SLMB) will qualify for old age assistance benefits or permanent and total disability benefits due to the raise in resource limits. DFS estimates that 7,301 QMB/SLMB eligibles will qualify when the resource eligibility limit is raised to $1,500 for individuals and $2,500 for a couple resulting in cases requiring case management services. DFS estimates that 1,558 new eligibles will qualify when the resource eligibility limit is raised resulting in new cases requiring case management services.

Based on the 29.12% participation for in-home services, the department estimates 2,580 [(7,301 + 1,558) x 29.12%] additional Medicaid recipients will access home care as an alternative to facility placement and will require case management in fiscal year 2003; 2,683 (2,580 x 104.00%) clients will require case management in fiscal year 2004 and 2,791 (2,580 x 104.00% x 104.00%) clients will require case management in fiscal year 2005. The department will need thirty-two (32) additional Social Service Worker II (SSW) positions the first year (FY2003) to case manage the new Medicaid eligibles based on current average caseload size of 80 cases per Social Service Worker (2,580 / 80 = 32.2500). The department will need thirty-four (34) SSW or two (2) additional SSW positions the second year (FY2004) (2,683 / 80 = 33.5375) and thirty-five (35) SSW or one (1) additional SSW position the third year (FY2005) (2,791 / 80 = 34.8875). The department will also need four (4) Home and Community Services Area Supervisor positions based on current supervision levels of one supervisor for every nine Social Service Workers and four (4) Clerk Typist II positions to provide clerical support to the Area Supervisor and SSW staff. The department will add the supervisor and clerical support staff in the first year.

The Social Service Worker IIs will be placed in the following counties/locations:

Year 1 (FY2003) (32 workers) One worker to be located in each of the following counties: Christian, Taney, Cape Girardeau, Carter, Chariton, Pettis, Buchanan, Camden, Macon, Franklin and Jefferson. Greene, Jasper, Taney, Texas, Wright, Dunklin, New Madrid, Pemiscot, St. Francois, Scott, Stoddard, Cass, Jackson, Pettis, Saline, Vernon, Andrew, Clinton, Grundy, Livingston, Adair, Boone, Crawford, Marion, Phelps, Pike, Pulaski, Randolph, Jefferson, St.

Charles, Prince Hall, and Wainwright.

Year 2 (FY2004) (34 workers or 2 additional workers). One worker each to be located in Cape Girardeau and Clay counties.

Year 3 (FY2005) (35 workers or 1 additional worker). Worker to be located in Scotland county.

ASSUMPTION (continued)

One (1) Area Supervisor position and one (1) Clerk Typist II position will be placed as follows: one each in Taney, Cape Girardeau, Jackson and Macon counties.

Social Service Worker II duties: responsible for the investigation of hotlines, pre-long-term care screenings, the eligibility determination and authorization of state-funded in-home services.

Home & Community Services Area Supervisor duties: supervise Social Service Workers responsible for the investigation of hotlines, pre-long-term care screenings, the eligibility determination and authorization of state-funded in-home services; provide oversight and accountability for the performance of the SSWs including case review, evaluation and guidance; act as the first point of contact for complaint resolution when clients are dissatisfied with services or staff performance.

Clerk Typist II duties: provide the necessary clerical support to the Area Supervisors, Social Service Workers, and the activities of the unit.

208.553 Establishes the Commission for the Pharmaceutical Investment Program for Seniors.

In determining the fiscal impact of this proposal, the Department of Health and Senior Services has made the following assumptions: The commission shall hold approximately 10 meetings during the first year and quarterly meetings in future years; The commission members shall be reimbursed for ordinary and necessary expenses incurred in the performance of their duties but shall receive no compensation for services; and The DHSS would employ staff necessary to support the performance of the commission's duties.

The DHSS staff will oversee and evaluate the work of the third-party administrator, support the commission, and perform program outreach with Area Agencies on Aging, public health clinics and other senior organizations. It is estimated the staff needed to perform these functions are a Public Health Manager (B2), two (2) Health Program Representative IIIs, a Research Analyst IV and two (2) Clerk Typist IIIs. These staff will be placed in Central Office.

Public Health Manager (B2) duties: responsible for program oversight and for supervising the

health program representatives, research analyst and the clerk typist IIIs.

Health Program Representative IIIs duties: responsible for assisting with oversight of the third-party administrator; provide support to the commission; and assist with the development of program outreach materials.

Research Analyst IV duties: responsible for assisting with oversight of the third party administrator especially in areas of cost-control measures, fraud and abuse detection system and
ASSUMPTION (continued)

auditing programs; and provide support to the commission.

Clerk Typist IIIs duties: responsible for providing clerical support to the public health manager, the health program representatives and the research analyst staff and providing clerical support to the commission.

208.556 Establishes the Pharmaceutical Investment Program for Seniors.

The DHSS is using assumptions provided by actuarial consultants with William M. Mercer as a model for the third-party administration of a Pharmaceutical Investment Program for Seniors. The assumptions are as follows:

- Benefit Design
- Income Tier I Less than $12,000 for an individual and Less than $17,000 for a couple; Tier II $12,001 - $17,000 for an individual and $17,001 - $23,000 for a couple.
- Enrollment Fee $25 Tier I; $35 Tier II.
- Deductible of $250 Tier I; $500 Tier II.
- Annual Benefit Maximum of $5,000 (both Tier I and Tier II).
- Coinsurance of 40% (both Tier I and Tier II).
- Eligible Seniors 287,820 Tier I; 94,830 Tier II.
- Participants - FY03 -- 37,260 Tier I, 13,220 Tier II; FY04 - 57,310 Tier I, 20,330 Tier II.
- Coinsurance applies to generic and preferred-brand prescription drugs. Drugs not on the voluntary preferred drug list are not covered under the program.
- 10% of all prescription drug costs will not be covered on the voluntary preferred drug list.
- A mandatory generic substitution provision applies whereby the participant pays coinsurance on the generic drug price + the difference in cost between the preferred brand and generic drug if a generic drug is available and the patient and/or the physician request that the preferred brand drug be dispensed.
- Medicaid eligibility will be increased to 100% of the Federal Poverty Level and the resource limit will be expanded by $500 (to $1500 individual/$2500 couple).
- Individuals who are enrolled in a prescription drug program with an actuarial value of

equal or greater value as the State Pharmaceutical Investment Program for Seniors (PIPS) are not eligible to enroll in the program.

- Coordination of Benefits will be enforced for individuals enrolled in both the State PIPS and a prescription drug program whose actuarial value is less than the State PIPS.
- Brand discount of AWP - 10.43% will be legislated.
- Generic discount of AWP - 20% will be legislated.
- Dispensing fee of $4.09 per prescription will be legislated.
- Rebates of 15% (of AWP) will be negotiated for brand name drugs. Note that there will be a lag of approximately 180 days for the State to receive the rebates.

ASSUMPTION (continued)

- Rebates of 11% (of AWP) will be negotiated for generic drugs. Note that there will be a lag of approximately 180 days for the State to receive the rebates.
- Claims processing fees of $0.60 per prescription will be negotiated. This includes PEP type activities to be performed by the third party administrator..
- Administrative expenses of $5.7 million in FY2003 and $3.7 million in FY2004 will be incurred in addition to the claims processing fees listed above. This also assumes that the State will have only one contractor to pay claims and perform utilization management and cost containment activities.
- A claim processing system that contains the capability to both process claims and administer pharmacy management programs will be used. Additional costs to enhance a claims processing system have been considered in this analysis (see next bullet for examples of these enhancements).
- Pharmacy management programs including edits, patient profiling, retrospective drug utilization review, prior authorization, dose optimization, case management and voluntary preferred drug list management will result in program savings of 5-7% (of the state's portion of program costs net of discounts, rebates and member cost sharing.)
- Mail service will not be included in the program.
- An enrollment fee of $25-$35 per year will be charged based on income level and will not apply towards the deductible.
- Proprietary prescription drug expenditure data for calendar year 1999 for over 1 million Medicare beneficiaries in Medicare+Choice HMOs, employer-sponsored retiree plans, Medigap Plans H-J, Medicaid programs and state pharmacy assistance programs was utilized to project program costs.

The following annual cost and utilization trends were utilized to project prescription drug expenditure data from calendar year 1999 to fiscal years 2003 and 2004:

2000 / 1999 - 19%
2001 / 2000 - 19%
2002 / 2001 - 18%
2003 / 2002 - 17%

2004 / 2003 - 16%

The enrollment fees and the rebates will be revenue deposited into the Pharmaceutical Investment Program for Seniors Fund. The cost for the administrator and other program costs are shown as PIPS Fund to the extent that revenues will support the expenses with the remainder of the costs shown as General Revenue.

Based on statewide guidelines and previous experience, the following amounts represent the average annual expense of an FTE:
Rent (Statewide Average) - $2,700 per FTE ($13.50 per sq. ft. x 200 sq. ft.);
ASSUMPTION (continued)

Utilities - $320 per FTE ($1.60 per sq. ft. x 200 sq. ft.);
Janitorial/Trash - $200 per FTE ($1.00 per sq. ft. x 200 sq. ft.);
Travel and Other Expenses - $5,000 per FTE for professional staff;
Office and Communication Expenses - $4,800 per FTE for all staff.

In addition to the above standard costs, systems furniture for the new HCS staff in Taney, Texas, Wright, Dunklin, New Madrid, Pemiscot, St. Francois, Stoddard, Cass, Jackson, Pettis, Andrew, Boone, Crawford, Pulaski and Macon counties and Prince Hall in St. Louis City in FY2003; Cape Girardeau and Clay counties in FY2004; and Scotland county in FY2005; and for the Commission of Pharmaceutical Investment Program for Seniors staff in Jefferson City in FY2002 will be needed at a cost of $4,500 per FTE. Desks will be needed for all HCS staff in locations without systems furniture.

Desktop PCs with software will be needed for the forty-three (43) HCS field staff and the six (6) PIPS Commission staff at a cost of $2,300 each.

FY02 costs for the PIPS Commission meetings and staff are based on the period January 1, 2002 through June 30, 2002. FY03 costs for the for the Area Supervisor, the Clerk Typist and Social Service Worker positions are based on the period July 1, 2002 through June 30, 2003. FY03 and FY04 costs include a 3.0% inflation adjustment for expense & equipment costs and a 2.5% inflation adjustment for personal services.

The Division of Aging, Institutional Services (DAIS) officials assume the increase in the number of individuals eligible for Medicaid services would not directly affect the number of surveys, inspections, and complaint investigations required in long-term care facilities at this time. At October 1, 2000, 79.4% of nursing facility beds certified for Medicaid/Medicare participation were occupied. The DAIS stated that if the number of individuals in future years resulted in new facilities being certified for Medicaid/Medicare participation, then the DAIS would need to request additional staff for inspection, survey, and complaint investigations based on the increase

in the number of providers.

The DA - Home and Community officials state the expansion of Medicaid eligible recipients is anticipated to increase the number of Medicaid eligible in-home service recipients. The DA believes it is reasonable to estimate that the new Medicaid recipients will access in-home services through DA's Home and Community Services at the same rate as the current population. The DA assumed the increase in the resource limits will allow individuals to enter the Medicaid program approximately two (2) months earlier. Therefore, the number of additional clients requiring case management will be 2/12ths per year or 16.67% of the total. The DA projected the client population will grow at a rate of 3.94% per year based upon the growth experienced in the OAA and PTD population provided by the DMS.

ASSUMPTION (continued)

Based on information provided by the DFS, it is projected that 14,549 persons will be eligible under the new resource limit ($2,500 for an individual and $4,000 for a couple) a portion of which will qualify for all Medicaid Services (QMB). The DA states this projection includes 7,614 persons living alone and 4,376 cases living with a spouse who are currently eligible as QMB/SLMB recipients. The remaining 1,625 are new cases living alone and 934 are new cases living with a spouse. The DA states these persons are expected to come from the general population and could qualify for benefits based on their age or disability.

The DOS - Research and Evaluation Unit estimates that in FY 02 the DA will serve 71,328 clients, or 39.13% of the 182,054 Medicaid eligibles and approximately 29.12% of these are projected to be in-home services clients. Based on the 29.12% participation for in-home services, the division estimates 4,237 (14,549 x 29.12%) additional Medicaid recipients will access home care as an alternative to facility placement.

Based upon the assumption that these clients will enter the program two (2) months earlier than before, the DA estimates 706 (4,237 x 16.6667%) clients requiring case management the first year. Based upon a growth factor of 3.94%, the DA estimates 734 (4,237 x 103.94% x 16.6667%) clients requiring case management the second year and 763 (4,237 x 103.94 x 103.94 x 16.6667%) clients requiring case management the third year. The DA will need nine (9) additional Social Service Worker II (SSW) positions the first year to case manage the new Medicaid eligibles based on the current average caseload size of 80 cases per SSW (706 / 80 = 8.825). The DA officials state the division will need nine (9) SSW positions the second year (734 /80 = 9.175) and ten (10) SSW positions or one (1) additional worker the third year (763 / 80 = 9.5375). The division will also need one (1) Home and Community Services Area Supervisor position based on current supervision levels of one supervisor for every nine SSWs and one (1) Clerk Typist II position to provide clerical support to the Area Supervisors and the SSWs. The DA officials stated they will add the supervisor and clerical support staff in the first

year.

The DA officials state the Social Service Worker IIs will be placed in the following counties/locations:

Year 1 (9 workers)

1	Christian	1	Cape Girardeau	1	Carter	1	Chariton
1	Pettis	1	Buchanan	1	Camden	1	Franklin
1	Jefferson						

Year 3 (10 workers) (1 additional worker)

1	Scotland

ASSUMPTION (continued)

The Area Supervisor position and the Clerk Typist II position will be placed in Christian County.

The DA officials state that Social Service Worker II duties include being responsible for the investigation of hotlines, per-long-term screenings, the eligibility determination and authorization of state-funded in-home services. Home and Community Services Area Supervisor duties include supervising Social Service Workers responsible for the investigation of hotlines, pre-long-term care screenings, the eligibility determination and authorization of state-funded in-home services; provide oversight and accountability for the performance of the SSWs including case review, evaluation and guidance; act as the first point of contact for complaint resolution when clients are dissatisfied with services or staff performance. The Clerk Typist II duties include providing the necessary clerical support to the Area Supervisors, SSWs, and the activities of the
unit.

The DA officials state that based on previous experience, the following amounts represent the average annual expense of an FTE:

- Rent (Statewide Average) - $2,700 per FTE ($13.50 per sq. ft. x 200 sq. ft.)
- Utilities - $320 per FTE ($1.60 per sq. ft. x 200 sq. ft.)
- Janitorial/Trash - $200 per FTE ($1.00 per sq. ft x 200 sq. ft.)
- Other Expenses - $3,906 per FTE (includes travel, office supplies, professional development, telephone charges, postage and all other expenses not itemized above.)

In addition to the above standard costs, the DA officials state systems furniture for the new staff in Pettis and Buchanan counties will be needed at a cost of $4,500 per FTE and desktop PCs will

be needed for all new staff at a cost of $2,099 per FTE. FY 02 costs are based on the ten (10) month period September 1, 2001 through June 30, 2002. FY 03 and FY 04 costs include a 3.0% inflation adjustment for expenses and equipment and a 2.5% inflation adjustment for personal services.

Oversight notes that the passage of Senate Bill 387 (1999) required the Director of the DOS to develop caseload standards based on the actual duties of employees in each program area of the department, after considering recommendations of the caseload standards advisory committee, established pursuant to section 660.021, RSMo, and consistent with existing professional caseload standards. Oversight requested a copy of the caseload study conducted by DOS and reviewed the findings and recommendations. The DOS officials stated that the caseloads standards for Division of Family Services was lowered from 480 cases to 300 cases per caseworker and the caseload standards for Division of Aging was lowered from 125 cases to 80 cases per caseworker. The caseload standard of 300 cases per caseworker for the Division of Family Services represents the lower end of the recommendations; the caseload standard of 80 cases per caseworker for the Division of Aging represents the high end of the recommendation.

ASSUMPTION (continued)

However, Oversight assumes the DOS would implement the provisions of the proposed legislation based on the current caseloads used by the DFS and DA. This would require 5 Social Service Worker II positions and 1 Clerk Typist II for the DFS and 5 IM Caseworkers, 1 HCS Area Supervisor, and 1 Clerk Typist II for the DA and related expense and equipment. As a result, Oversight has ranged the cost of implementing this legislation between $8,265,642 and $8,533,430 to the General Revenue Fund for FY 02.

Oversight assumes the following:

Total Households 65 and over 21,745 US (IN THOUSANDS)

		Missouri	Individuals	
Missouri Households 65 and over (x 1.34)			525,811	Households
Under $2,500	263	1.21%	6,360	8,522
$2,500 to $4,999	303	1.39%	7,327	9,818
$5,000 to $7,499	1,202	5.53%	29,065	38,947
$7,500 to 9,999	1,625	7.47%	39,294	52,654
$10,000 to $12,499	1,786	8.21%	43,187	57,870
$12,500 to $14,999	1,525	7.01%	36,876	49,413
$15,000 to $17,499	1,457	6.70%	35,231	47,210

$17,500 to $19,999	1,322	6.08%	31,967	42,836
$20,000 to $22,499	1,240	5.70%	29,984	40,179
$22,500 to $24,999	1,206	5.55%	29,162	39,077
Total	11,929	54.86%	288,452	386,526

Individuals w/o Insurance 47.00%	Participation Rate 75.00%	Individuals 43.00%	Couples 57.00%	Prescription Costs per Person
4,005	3,004	1,292	1,712	1,335
4,614	3,461	1,488	1,973	1,335
18,305	13,729	5,903	7,826	1,335
24,747	18,560	7,981	10,579	1,335
27,199	20,399	8,772	11,628	1,335
23,224	17,418	7,490	9,928	1,335
22,189	16,642	7,156	9,486	1,335
20,133	15,100	6,493	8,607	1,335

ASSUMPTION (continued)

18,884	14,163	6,090	8,073	1,335
18,366	13,775	5,923	7,852	1,335
Total	181,667	136,251	58,588	77,663

Costs Per Individual	Less Deductible	Coinsurance 40.00%	State Cost
1,724,406	322,923	560,594	840,890
1,986,674	372,036	645,855	968,782
7,881,128	1,475,867	2,562,104	3,843,157
10,654,603	1,995,244	3,463,744	5,195,615
11,710,228	2,192,927	3,806,921	5,710,381
9,998,935	3,744,919	2,501,606	3,752,409
9,553,081	3,577,933	2,390,059	3,585,089
53,509,054	13,681,848	15,930,882	23,896,324

Costs Per	Less	Coinsurance	State

Couple	Deductible	40.00%	Cost
4,571,682	856,120	1,486,225	2,229,337
5,266,995	986,329	1,712,267	2,568.400
20,894,152	3,912,763	6,792,556	10,188,834
28,247,086	5,289,717	9,182,948	13,774,422
31,045,721	5,813,805	10,092,766	15,139,149
26,508,804	4,964,196	8,617,843	12,926,765
25,326,772	4,742,841	8,233,572	12,350,359
22,980,091	8,606,776	5,749,326	8,623,989
21,554,700	8,072,921	5,392,711	8,089,067
20,963,684	7,851,567	5,244,847	7,867,270
77,034,267	51,097,034	62,505,062	93,757,592

Using United States Bureau of Census data, Oversight assumes program costs of $140,008,160 annually. Oversight assumes enrollment fees of $3,335,430 annually and pharmaceutical rebates of $33,912,936 annually.

ASSUMPTION (continued)

Officials from the **Office of Administration - Division of Budget and Planning** (**BAP**) state this proposal would eliminate the senior pharmacy tax credit beginning with calendar year 2002. Removing the credit would increase General Revenue by $94.5 million in FY03 and $99.2 million in FY04. A 5% growth rate is assumed. This is based on actual data for FY01 of $85.7 million.

In addition, BAP states the enrollment fee for the pharmacy investment program for seniors would increase total state revenue. Department of Health and Senior Services should be providing information about the enrollment fee, as well as the costs of the pharmacy investment program for seniors.

Amendment House Substitute Amendment 1 for House Amendment 4

Officials from the **Department of Mental Health (DMH)** expect that the impact to the DMH will be minimal because it is believed that the majority of DMH current clients are denied Medicaid eligibility based on the income limits rather than the resource ceiling. However, there is a potential minimal cost savings to the DMH if any existing DMH clients become Medicaid eligible through this proposal. Services provided by contracted providers to non-Medicaid eligible clients are paid at 100%. With the increase in resource ceilings, some of those clients could become Medicaid eligible, and the DMH would then be reimbursed by Medicaid for 60%

of those charges. If any DMH operated facilities provide covered services to any newly eligible clients, there would be a very minimal increase in general revenue. The DMH cannot determine a dollar amount of potentially new revenue or cost savings because the DMH does not have any statistics on how many clients currently are not eligible due to the resource ceiling.

The **Department of Social Services (DOS)** assumes this proposal would also increase the resource limits for those populations receiving Medicaid coverage under Chapter 208 RSMo, with the exception of Temporary Assistance, which is included in this provision. The increases in the resource ceilings would raise the resource maximums for a single individual from $1,000 to $2,500 and for a married couple from $2,000 to $4,000.

DOS - Division of Family Services

The **Division of Family Services (DFS)** assumes that 65% of the total population would qualify for the single resource maximum and 35% of the total population would qualify for the couple resource maximum, as reported by the Health Care Finance Administration (Medicare Current Beneficiary Survey Data Tables, 1997, Table 1.2) The DFS assumes 11,882 Qualified Medicare Beneficiary (QMB) cases and 6,860 Specified Low-income Medicare Beneficiary (SLMB) cases (data obtained from the Department of Social Services, FY 2000 Annual Data Report published by Research and Evaluation). The DFS assumes 65% of the current QMB and SLMB program ASSUMPTION (continued)

participants are living alone. The DFS further assumes that 62.5% of this population would be eligible for Medicaid based on the increased resource limits (% of the current resource limit for SLMB/QMB). For this population, the income limits are greater than the SSI maximum; therefore, this population would be spenddown.

18,742	Active QMB/SLMB cases
x .65	% living alone
12,182	Living alone
x .625	% eligible based on current resource limits
7,614	# eligible based on resource maximum of $2,500

The DFS assumes 35% of the current QMB and SLMB program participants are living with a spouse. The DFS assumes that 66.7% of this population would be eligible for Medicaid based on the increased resource limits (% of the current resource limit for SLMB/QMB). For this population the income limits are greater than the SSI maximum; therefore, this population would be spenddown.

18,742	Active QMB/SLMB cases
x .35	% living with spouse

6,560	Living with a spouse
x .667	% eligible based on current resource limits
4,376	# eligible based on resource maximum of $4,000

The DFS assumes the global Medicare population in Missouri to be 800,000. The DFS assumes this group to be the new population from outside of the current welfare rolls to seek Medicaid benefits.

800,000	Medicare Population
520,000	Living Alone (65%)
280,000	Living with a Spouse (35%)

The DFS assumes that 6.25% of the single Medicare population will be eligible to apply for Medicaid under the new expanded resource limits. The DFS further assumes that 5% of this population will apply and be found eligible for Medicaid.

520,000	Medicare Population Living Alone
x 6.25%	% eligible to apply
32,500	
x 5%	% applying and found eligible
1,625	New cases living alone

ASSUMPTION (continued)

The DFS assumes that 6.67% of the Medicare population living with a spouse will be eligible to apply for Medicaid under the new expanded resource limits. The DFS further assumes that 5% of this population will apply and be found eligible for Medicaid.

280,000	Medicare Population Living with a Spouse
x 6.67%	% eligible to apply
18,676	
x 5%	% applying and found eligible
934	New cases living with a spouse

The DFS assumes an average adult Medicaid caseload to be 300 cases. The DFS estimates the total population to include:

7,614	Active QMB/SLMB cases living alone
4,376	Active QMB/SLMB cases living with a spouse
1,625	New cases living alone
934	New cases living with a spouse

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14,549 Total cases

The DFS estimates the active QMB/SLMB cases that are currently being maintained in a caseload would not require additional staff.

1,625 New cases living alone
934 New cases living with a spouse
2,559 New eligibles

The DFS assumes with 2,559 new eligibles that 8.53 (9) additional caseworkers would be needed to maintain the new cases (2,559/300). Caseworker duties and responsibilities include taking and processing applications for eligibility, responding and answering both written and telephone requests for information or reported changes, and maintaining all active cases in their caseloads.

The DFS assumes two (2) additional Clerk Typist II will be needed to support the additional caseworkers. Clerk Typist II duties and responsibilities include maintaining reports, typing letters, systems information (input/extraction), filing, accepting incoming phone calls for messages, maintaining stocks of supplies and forms, and other essential duties as support staff.

DOS - Division of Medical Services

The Division of Medical Services (DMS) states that it projects that 14,549 persons would ASSUMPTION (continued)

become Medicaid eligible if the resource limit is increased to $2,500/$4,000. The estimate was done by the DFS. The DMS assumes a twelve month phase-in for the 14,549 new eligibles. The DMS projects the group will experience growth at the same rate as the Old Age Assistance (OAA) and Permanently and Totally Disabled (PTD) population (an estimate of 3.94% for FY 02 - FY 02 Budget Request for Caseload Growth). This growth rate is used for FY 03 and FY 04.

The DMS states the cost per eligible is a weighted average of the last three (3) months of actual expenditures for the OAA and PTD eligibles. The costs do not include NF and state institutions expenditures. The FY 02 cost per eligible is $862.27, $896.76 for FY 03, and $932.63 for FY 04. The cost was inflated by 4% (fiscal note standard for medical care) for FY 03 and FY 04. The cost per eligible includes costs for mental health services (General Revenue appropriated to the Department of Mental Heath). The DMS assumes the increase in the resource limit to $2,500/$4,000 will allow individuals to enter the Medicaid program earlier - the individual will not have to spend his resources to become Medicaid eligible. The DMS projects the individual will become Medicaid eligible two (2) months sooner if the resource limit is increased (1,500 increase in resource limit/$826.27 cost per eligible per month = 2 months). The new cost

associated with the increase limit is two (2) months of Medicaid per eligible. The cost per eligible was multiplied by the number of new eligibles for that month to arrive at a cost per month.

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
GENERAL REVENUE FUND			
Savings - Office of Administration			
Repeal of prescription tax credit	$0	$94,500,000	$99,200,000
Transfer Out - Office of Administration			
To Pharmaceutical Investment Program for Seniors Fund	$0	($101,712,544)	($93,083,911)
Costs - Department of Social Services - Division of Family Services			
Personal services (2.01)	($29,185)	($59,830)	($61,325)
Fringe benefits	($9,727)	($19,941)	($20,440)
Expense and equipment	($22,475)	($9,583)	($9,871)
Total Costs - DFS	($61,387)	($89,354)	($91,636)
Costs - Department of Social Services - Division of Medical Services			
Processing costs - resource increase	$0	($50,000)	($50,000)
Program costs - resource increase	$0	($17,534,519)	($24,462,462)
Processing costs - federal poverty	$0	($25,000)	($25,000)
Program costs - federal poverty	$0	($4,226,043)	($4,564,305)
Total Costs - DMS	$0	($21,835,562)	($29,101,767)
Costs - Department of Health and Senior Services - Division of Aging			
Personal services (33.3 FTE)	($121,239)	($1,175,462)	($1,204,849)
Fringe benefits	($40,409)	($391,781)	($401,576)
Expense and equipment	($352,089)	($215,457)	($221,919)
Total Costs - Division of Aging	($513,737)	($1,782,700)	($1,828,344)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**($575,124)**	**($30,920,160)**	**($24,905,658)**

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FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
PHARMACEUTICAL INVESTMENT PROGRAM FOR SENIORS FUND			
Income - Department of Health and Senior Services - Division of Aging			
Enrollment fees	$3,335,430	$3,335,430	$3,335,430
Pharmaceutical rebates	$0	$19,839,068	$46,026,637
Total Income - Division of Aging	$3,335,430	$23,174,498	$49,362,067
Transfer In - Office of Administration			
From General Revenue Fund	$0	$101,712,544	$93,083,911
Costs - Department of Health and Senior Services - Division of Aging			
Program administration	$0	($7,233,126)	($5,967,435)
Drug Costs	$0	($117,653,916)	($136,478,543)
Total Costs - Division of Aging	$0	($124,887,042)	($142,445,978)
ESTIMATED NET EFFECT ON PHARMACEUTICAL INVESTMENT PROGRAM FOR SENIORS	**$3,335,430**	**$0**	**$0**
FEDERAL FUNDS			
Income - Department of Social Services			
Medicaid reimbursements	$442,419	$28,398,681	$39,201,975
Costs - Department of Social Services - Division of Family Services			
Personal services (.99)	($14,375)	($29,468)	($30,205)
Fringe benefits	($4,791)	($9,822)	($10,067)
Expense and equipment	($11,070)	($4,720)	($4,862)
Total Costs - DFS	($30,236)	($44,010)	($45,134)
Costs - Department of Social Services - Division of Medical Services			
Processing costs	$0	($50,000)	($50,000)
Program costs	$0	($27,495,062)	($38,331,287)

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
Total Costs - DMS	$0	($27,545,062)	($38,381,287)
Costs - Department of Health and Senior Services - Division of Aging			
Personal services (14.7 FTE)	($248,063)	($508,529)	($521,242)
Fringe benefits	($82,679)	($169,493)	($173,730)
Expense and equipment	($81,441)	($131,587)	($80,582)
Total Costs - Division of Aging	($412,183)	($809,609)	($775,554)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

Small pharmacies may be impacted by this proposal due to the change in administration of the program.

DESCRIPTION

This proposal would establish a Pharmaceutical Investment Program for eligible seniors who reside in Missouri. In its main provisions, the proposal would: (1) Repeal the current $200 prescription tax credit for eligible seniors; (2) Revise the current resource limit used to determine eligibility for persons who apply for public assistance. The resource limit for an individual would be increased from $1,000 to $2,500; for a married couple, the resource limit is increased from $2,000 to $4,000; (3) Increase the income limit to 100% of the federal poverty level for persons eligible to receive Medicaid; (4) Establish an 11-member Commission for the Pharmaceutical Investment Program for Seniors within the Division of Aging in the Department of Health and Senior Services. The composition and selection of members and duties of the commission are contained in the proposal; (5) Establish the Pharmaceutical Investment Program for Seniors within the Division of Aging in the Department of Health and Senior Services. Various terms are defined; (6) Require the commission to govern the program and to solicit requests for proposals to administer the program from private contractors; (7) Require the

commission to select a bid from the submitted proposals. If no bids are received, the program would be jointly administered by the Department of Health and Senior Services and the Department of Social Services; (8) Set eligibility criteria for participation in the program. Residents would be eligible to apply to the program if they are 65 years of age, have not received pharmaceutical benefits for at least 6 months prior to applying to the program, have not received Medicaid benefits, and meet income eligibility guidelines; (9) Establish income eligibility limits of $17,000 for individuals and $23,000 for married couples; (10) Make the program the payer of last resort and not an entitlement; (11) Require that seniors submit an annual application to the Division of Aging or the division's designee. The commission would develop and implement a means test requiring applicants to meet the income requirement of the program; (12) Prohibit requiring applicants to accept Medicaid benefits in lieu of participating in the program; (13) Require that participants pay a deductible to participate in the program. Deductible amounts would be $250 or $500 per participant, depending on marital status and household income; (14) Require that all household income levels established for participation in the program be adjusted annually by an amount equal to the cost-of-living adjustment for the federal poverty level established by the federal Department of Health and Human Services; (15) Require that enrollees pay 40% of the purchase price of prescription drugs. In addition, eligible enrollees would be required to pay an annual co-insurance amount of $25 or $35 based on marital status and income level; (16) Establish an annual program benefit limit of $5,000 per enrollee; (17) Allow the Department of Health and Senior Services to enter into a contract with any private individual, corporation, or agency to implement the program; (18) Require the division to utilize Area Agencies on Aging;senior citizen centers, and related entities to provide outreach, enrollment assistance, and education relating to the program; (19) Require the commission to submit quarterly reports to the Governor, Senate Appropriations Committee, House of Representatives Budget Committee, Speaker of the House of Representatives, and President Pro Tem of the Senate; (20) Require that program benefits be supported by moneys appropriated by the General Assembly; (21) Require the commission to implement cost control measures if projected costs

DESCRIPTION (continued)

exceed the current program appropriation; (22) Allow the division to request a supplemental appropriation to meet additional costs and requires implementation of cost control measures; (23) Require the program to cover eligible costs not covered by a federal pharmaceutical assistance program if established; (24) Require the commission to develop rules to implement the program; (25) Make any person who engages in fraudulent activities in order to participate in the program guilty of a misdemeanor and forfeits his or her rights to participate in the program; (26) Require the program to be fully operational by July 1, 2002. An initial enrollment period would be from April 1, 2002 through May 30, 2002. A second initial enrollment period would be held from November 1, 2002 through December 15, 2002 to allow persons who did not enroll during the initial enrollment period to enroll for the program for calendar year 2003. Beginning with calendar year 2004, open enrollment periods would be held from November 1 through December 15 of the preceding calendar year; (27) Allow an individual a 30-day enrollment period outside

the established enrollment periods; (28) Require that the program use generic prescription drugs when available. Enrollees may receive brand name prescription drugs when a generic prescription drug is available only if both the prescribing physician and the enrollee request the brand name prescription drug, the enrollee pays the co-insurance on the generic drug, and the enrollee pays the difference in price between the brand name drug and the generic drug; (29) Require that pharmacists participating in the program be reimbursed for costs resulting from obtaining and dispensing medications. Reimbursement formulas for brand name and generic medications are contained in the proposal; (30) Require the division to issue a certificate of participation to pharmaceutical manufacturers who participate in the program. A manufacturer can apply for participation in the program by submitting an application approved by the commission; (31) Require pharmaceutical manufacturers to provide quarterly rebates under the program. The division would be required to negotiate annually with manufacturers for the rebate amounts. Rebates for brand name prescription drugs may not be less than 15% and rebates for generic prescriptions may not be less than 11%. Rebates would be used to fund the program; (32) Prohibit a pharmaceutical manufacturer's status under the current Medicaid program from being affected if the manufacturer refuses to participate in the program; and (33) Create a Pharmaceutical Investment Program for Seniors Fund which would be administered by the State Treasurer. The revenue sources for the fund are specified in the proposal and funds would not revert to the General Revenue Fund.

The proposal contains an emergency clause.

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Office of Attorney General
Office of State Courts Administrator
Department of Health and Senior Services
Department of Revenue
Department of Social Services
Office of State Treasurer

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Jeanne Jarrett, CPA
Director

September 10, 2001